

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **333**

1. PLACE OF DEATH
County **Kicomic**
City or town **Salisbury**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
P.B. Hospit
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State **Md.** County **Kicomic**
City or town **Mandela**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **R.O.**
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME **Louis James Adkins** 3. (b) Social Security Number

4. Sex **Male** 5. Color of race **White** 6. (a) Single, married, widowed, or divorced **Married**
6.(b) Name of husband or wife **Bessie Lee Adkins**
7. Birth date of deceased (mo., day, yr.) **Jan. 19th 1890**
8. AGE: Years **58** Months Days If less than one day hrs. min.
9. Birthplace **R.O. Salisbury Md.**
(Town, county, and state)

10. Usual occupation **Farmer**
11. Industry or business
12. Name **Benj William Barton Adkins**
13. Birthplace **R.O. Salisbury Md.**
14. Maiden name **Georgia Althea Bradley**
15. Birthplace **R.O. Mandela Md.**

16. Informant **Mr. James Ralph Adkins**
R.O. Mandela Maryland
17. Burial **Jan. 22-1948**
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematorium **Parson's Corner**
Location **Salisbury Maryland**
18. Funeral director **Walter R. Holloman**
Address **Salisbury Maryland.**

19. **1/22/48** Registrar **Walter R. Holloman**
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH **Jan. 19th 1948** at **10:08 P**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **January 10** to **Jan 19** 19**48**
and that I last saw him alive on **January 18** 19**48**
Immediate cause of death **Hodgkin's disease** DURATION **2 years**
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

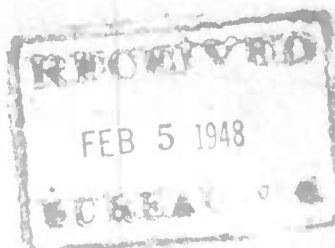
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE **J.V. Solley, M.D.** M. D. or other
Address **Salisbury Md.** Date signed **Jan 21, 48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

00971



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 hrs 20 min
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 20 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Baby Boy Allen

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Jan. 14 - 2:25 PM 1948
 8. AGE: Years _____ Months _____ Days _____ If less than one day
Newborn 20 hrs. 20 min.

9. Birthplace

Wicomico
(Town, county, and state)

10. Usual occupation

new born

11. Industry or business

FATHER

12. Name

Olin Allen

13. Birthplace

Maryland

MOTHER

14. Maiden name

Bear Allen

15. Birthplace

Maryland

16. Informant

Hospital Chart

Address

Peninsula Hospital

17. (Burial, cremation, or removal. Which?)

✓

Date thereof

1-16-1948
(month) (day) (year)

Cemetery or crematory

Peninsula General Hospital

Location

Salisbury, Maryland

18. Funeral director

Address

Peninsula General Hospital
Salisbury, MD

19. (Date rec'd by registrar)

1/16/48

19. (Date rec'd by registrar)

4/8

19. (Date rec'd by registrar)

Warrant by John

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 19 48 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____ to 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Prematurity

Due to

Preeclampsia

Due to

Pregnancy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

W. B. Smith

M. D. or other

Address

124 E. Main ST.Date signed 1/18/48

RECEIVED

FEB 5 1948

STEELE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00973 339

1. PLACE OF DEATH:

County Thionia
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years 6 mo.
 Hospital, institution, or street address where death occurred:
John B. Paves Home
 How long in hospital or institution? 8 years 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Harister
 City or town Shaw Mill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Emma K. Bachm

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Charles L. Bachm
 7. Birth date of deceased (mo., day, yr.) July 9, 1861
 8. AGE: Years 86 Months 5 Days 29 If less than one day _____ hrs. _____ min.
 9. Birthplace Baltimore Co., Md.
 (Town, county, and state)
 10. Usual occupation at home
 11. Industry or business _____

12. Name John A. Procter
 13. Birthplace Thionia Co., Md.
 14. Maiden name Elizabeth Ellen Price
 15. Birthplace Thionia Co., Md.
 16. Informant William G. Keiser, Jr.
 Address Shaw Mill, Md.
 17. Burial Date thereof 11/1/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory all Hallams
 Location Shaw Mill, Md.
 18. Funeral director The Hill, Green Co.
 Address Salisbury, Md.

19. 1/13, 1948 Registrar Harrie L. Johnson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1948 at 11:55 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7th to Jan 8th 1948
 and that I last saw him alive on Jan 8th 1948

Immediate cause of death Heart failure
 Due to Hypertension
 Due to arterio-sclerosis
 Other conditions Unrecorded

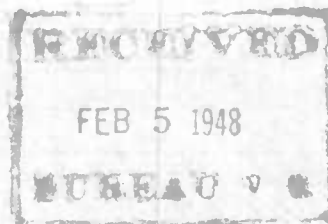
(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE C. J. Hearn M. D. or other _____
 Address _____ Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 389

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1. PLACE OF DEATH:

County Wicomico
 City or town Willards
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Willards
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Cornelia Ellen Baker

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Cornelius Baker

7. Birth date of

deceased (mo., day, yr.)

June 6, 1881
 8. AGE: Years 66 Months 7 Days 22 It less than one day _____ hrs. _____ min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Housewife

FATHER

12. Name

Ninam Jackson Cooper

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary Elizabeth Jarman

15. Birthplace

Md.

16. Informant

Mrs. Arthur Patey

Address

Willards, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof _____ (month) (day) (year)

Cemetery or crematory

Willards, Md.

Location

Willards, Md.

18. Funeral director

W. Cashy Watson

Address

Silveryville, Del.

19.

(Date rec'd by registrar)

1/29, 1948 Reginald S. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1948, at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1940 to day of death 1948and that I last saw her alive on 1-28-48 1948

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

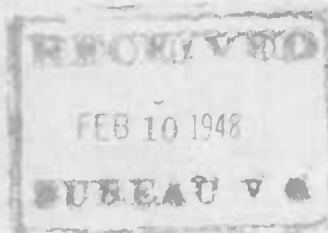
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Frank R. Lewis M.D. M. D. or otherAddress Willards, Md. Date signed 1-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 1/30/46
 Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Somerset
 City or town Eden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt. #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

BAKER

Elijah Asbury

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Bertie Mitchell Baker
 7. Birth date of deceased (mo., day, yr.) April 14, 1886 6.(c) If alive, give age years
 8. AGE: Years 61 Months 9 Days 5 If less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business

FATHER 12. Name Peter Baker
 13. Birthplace Maryland
 MOTHER 14. Maiden name Ellen Cooper
 15. Birthplace Maryland

16. Informant patient on admission
 Address

17. Burial Date thereof 1-21-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cooper Cemetery
 Location Willard, Maryland

18. Funeral director Wilson Funeral Home
 Address Business Ave, Md

19. 1/21/48 (Date recorded by registrar) Registrar Harriet L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1948 at 8:20p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947 to Jan. 19, 1948
 and that I last saw him alive on January 19, 1948

Immediate cause of death Cerebral Hemorrhage DURATION 2 days

Due to chronic Hepatitition 4 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

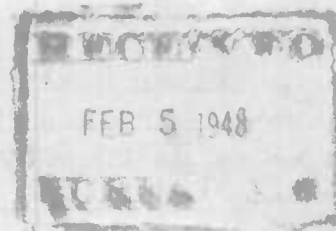
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. H. Hunter MD M. D. or other

Address Salisbury, Maryland Date signed 1/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 337

1. PLACE OF DEATH:

County Wicomico
 City or town Gesterville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico
 City or town Gesterville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Margaret E. Barkley

3. (b) Social Security Number

4. Sex F 5. Color or race col 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) April 13, 1882 8. (c) If alive, give age years
 8. AGE: Years 65 Months 8 Days 25 If less than one day
 hrs. min.

9. Birthplace Nantuxoke, Wicomico, Md.
 (Town, county, and state)

10. Usual occupation Household work

11. Industry or business

12. Name unknown

13. Birthplace "

14. Maiden name Matilda Barkley

15. Birthplace Nantuxoke, Md.

16. Informant Willie Mutter

Address Gesterville, Md.

17. Burial Date thereof 1/11/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gesterville Cemetery

Location Gesterville, Md.

19. Funeral director W. H. H. H. H. H.

Address Bivalve, Maryland

Jan. 10 19 48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 19 48, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-25 19 47 to Jan 8 19 48

and that I last saw him alive on Jan 8 19 48

Immediate cause of death Arteriosclerosis DURATION

Heart Disease

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Thurnell, MD M. D. or other

Address 800 W Main St. Date signed 1/9/48

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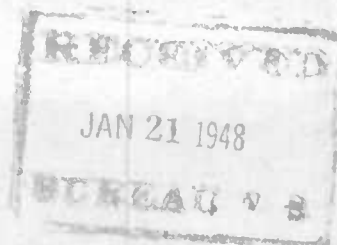
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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Thiomas
 City or town Salisbury, Md. Ral 1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 days
 Hospital, institution, or street address where death occurred:
Lawrence Nursing Home
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Thiomas
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 143 St. College Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Harry Black

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1877 6. (c) If alive, give age ✓ years

8. AGE: Years 70 Months 11 Days 5 If less than one day hrs. min.

9. Birthplace Lucas Co., Delaware
 (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Mrs. Lillian C. Mearns

13. Birthplace Lucas Co., Del.

14. Maiden name Lauria Mearns

15. Birthplace Lucas Co., Del.

16. Informant Mrs. Lillian C. Mearns

Address 143 St. College Ave., Salisbury, Md.

17. Burial Date thereof 1/23/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Methodist

Location Salisbury, Delaware

18. Funeral director W. Hall & John O.

Address Salisbury, Md.

19. 1/23, 1948 Harriet L. Johnson
 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1948 at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 48 to Jan 21 19 48 and that I last saw him alive on Jan 21 19 48

Immediate cause of death Myocardial failure DURATION 3 days

Due to Arteriosclerosis of heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick P. Mearns, M.D.

Address Salisbury, Md. Date signed 1/23/48

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *McComie*
County *Salisbury*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
P.S. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-born infants give residence of mother)
State *Md.* County *McComie*
City or town *John*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *R.D. #2*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME *Franklin Glenmore Brumby* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
6. (b) Name of husband or wife *Anna E. Brumby*
7. Birth date of deceased (mo., day, yr.) *Feb. 11-1878* 6. (c) If alive, give age *67* years

8. AGE: Years *69* Months *11* Days *7* If less than one day
9. Birthplace *Monticello Co. Md.*
(Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business *George Brumby*

12. Name *George Brumby*

13. Birthplace *Monticello Co. Md.*

14. Maiden name *Martha Pusey*

15. Birthplace *Monticello Co. Md.*

16. Informant *Mr. Theresa Napier*

Address *Spring Hill Road, Salisbury Md.*

17. (Burial, cremation, or removal, Which?) *Buried* Date thereof *Jan. 20/1948*
(month) (day) (year)

Cemetery or crematory *Episcopal Cem.*
Location *Salisbury Md.*
18. Funeral director *Holladay + Co. Walter R. Holladay*
Address *Salisbury Md.*

MEDICAL CERTIFICATION
20. DATE OF DEATH *Jan. 18. 48* at *1235* PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 31* to *Jan 15* 19 *48*
and that I last saw him alive on *Jan 15* 19 *48*

Immediate cause of death *Cardiac Failure*

Due to *Ch. Hg. Glauk*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

2. VIOLENCE: if death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?
23. SIGNATURE *W. R. Holladay* M. D. or other
Address *Salisbury* Date signed *1/20/48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1948
FEB 5 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No. 178
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Raymond Taylor Carter

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elsie M. Carter
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct. 26 1881

8. AGE: Years 66 Months 2 Days 15 If less than one day
hrs. min.

9. Birthplace Columbus, Ohio
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William Allen Carter

13. Birthplace Ohio

MOTHER 14. Maiden name Ella M. Taylor

15. Birthplace Ohio

16. Informant William Carter

Address Willards, Md.

17. Burial Date thereof Jan 14, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Hope

Location Willards, Md.

18. Funeral director M. Pasha Watson

Address Lithywell, Del.

19. 1/15/48 Registrar

(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1948 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1947 to day of death 1948 and that I last saw him alive on day of death 1948

Immediate cause of death Leukemia, myelogenous DURATION 6-mo.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

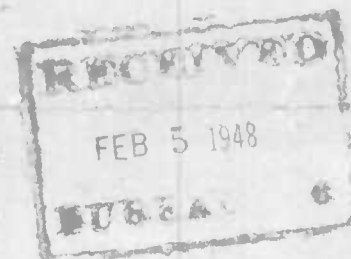
23. SIGNATURE Frank R. Lewis M.D. M. D. or other

Address Willards, Md. Date signed 1-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(Month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nor

19

to

Jan

19

and that I last saw him alive on

Jan

7

19

Immediate cause of death

Carcinoma of Prostate

DURATION

1 yr. -

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. L. Lawry M.D.

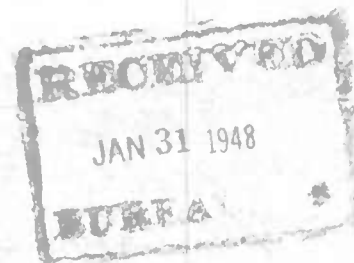
M. D. or other

Address

Frederick

Date signed

1-8-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00982

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Penninsula General HospitalCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County AccomackCity or town New Church
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)2.(a) If veteran, name war. ✓

3. (a) FULL NAME

Leustis Samuel

3. (b) Social Security Number

4. Sex

Male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 4, 1933

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

14914

hrs.

min.

9. Birthplace

New Church Virginia
(Town, county and state)

10. Usual occupation

Student

11. Industry or business

School

FATHER

12. Name

Elmer Holden

13. Birthplace

Withams, VA

MOTHER

14. Maiden name

Sarah Cistis

15. Birthplace

New Church, VA

16. Informant

Sarah Holden

Address

New Church, VA R.F.D.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 21, 1948
(month) (day) (year)

Cemetery or crematory

Cool Spring

Location

N. Girdle, Maryland

18. Funeral director

J. Edgar Thomas

Address

Accomack, VA

19.

(Date rec'd by registrar)

19. 4.8.48

Registrar

W. H. Harrison

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 18 - 1948 at 8:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 16, 1948 to Jan 18, 1948and that I last saw him alive on Jan 18, 1948

Immediate cause of death

Generalized Peritonitis
Ruptured appendix

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

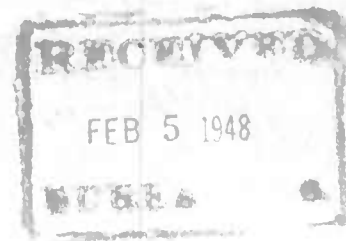
23. SIGNATURE

W. H. Harrison

M. D. or other

Address

Salisbury, MDDate signed 1-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Ocean City Rd., R.D. #4
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Ocean City Rd., R.D. #4
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Louis August Deaton, Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ella Blanchard Deaton
 6. (c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) April 20, 1889
 8. AGE: Years 58 Months 9 Days 0 It less than one day hrs. min.

9. Birthplace Ronaldsonville La.
(Town, county, and state)10. Usual occupation Artist

11. Industry or business

12. Name Louis August Deaton, Jr.13. Birthplace Ronaldsonville, La.14. Maiden name Helen Trappe15. Birthplace Ronaldsonville, La.16. Informant Mrs. Louis A. Deaton Jr.Address Ocean City Rd., R.D. #417. Burial Date thereof 11/21/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wicomico Memorial ParkLocation Salisbury Md.18. Funeral director The Will & Johnson Co.Address Salisbury, Maryland19. 1/21/48 19 48 Barrie L. Johnson
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1948 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 19, 1948 to Jan. 19, 1948and that I last saw him alive on Jan. 19, 1948

Immediate cause of death

Cerebral HemorrhageDue to Long city of vas system

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

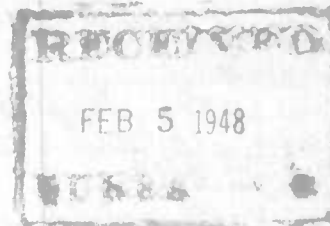
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. MandyAddress Salisbury Md. Date signed 1/20/48

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH County <u>Pocomoke</u> City or town <u>Pittsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>R.O.</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Pocomoke</u> City or town <u>Pittsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>R.O. #1</u> (If rural, give LOCATION) 2. (a) If veteran, name war	
3. (a) FULL NAME <u>John Handy Dennis</u>		3. (b) Social Security Number	
4. Sex <u>Male</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Married</u> 6. (b) Name of husband or wife <u>Mollie J. Dennis</u> 6. (c) If alive, give age <u>Dead</u> years 7. Birth date of deceased (mo., day, yr.) <u>July 7 - 1876</u> 8. AGE: Years <u>71</u> Months <u>5</u> Days <u>29</u> It less than one day hrs. min. 9. Birthplace <u>Pittsville Maryland</u> (Town, county, and state) 10. Usual occupation <u>Farmer</u> 11. Industry or business		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>6 Jan 6th</u> 19 <u>48</u> at <u>4:45</u> P.M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>10 Dec</u> 19 <u>47</u> to <u>6 Jan</u> 19 <u>48</u> and that I last saw him <u>121</u> alive on <u>6 Jan</u> 19 <u>48</u> Immediate cause of death <u>Cerebral Hemorrhage</u> Due to <u>Arteriosclerosis</u> <u>Generalized</u> Due to Other conditions (Include pregnancy within 8 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Cause of injury Injured at work? 23. SIGNATURE <u>Hermon R. Ralston M.D.</u> Address <u>5 Bay St. Bel Air, Md.</u> Date signed <u>6 Jan 48</u>	
12. Name <u>William A. Dennis</u> 13. Birthplace <u>Pittsville Md.</u> 14. Maiden name <u>Rebecca Dennis</u> 15. Birthplace <u>Pittsville Md.</u> 16. Informant <u>Mr. Charles H. Dennis</u> Address <u>R.O. Pittsville Md.</u> 17. Burial <u>Pittsville Am.</u> Date thereof <u>Jan 8 - 48</u> (Burial, cremation, or removal) (month) (day) (year) Cemetery or crematorium Location <u>Pittsville Maryland</u> 18. Funeral director <u>W. H. May & Co. Walter R. Helling</u> <u>Salisbury Md.</u> 19. Date rec'd by Registrar <u>1/7/48</u> Registrar <u>W. H. May</u>		DURATION <u>3 months</u>	

RECEIVED

FEB 2 1948

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....Wicomico
City or town.....Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....Twenty five years
Hospital, institution, or street address where death occurred:
no
How long in hospital or institution?.....no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....Md County.....Wicomico
City or town.....Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.....no
(If rural, give LOCATION)
2.(a) If veteran, name war.....no

3. (a) FULL NAME

William A Duffield

3. (b) Social Security Number

no

4. Sex.....male 5. Color or race.....a.a. 6.(a) Single, married, widowed, or divorced.....single

6.(b) Name of husband or wife.....Katie Duffield
Dead 6.(c) If alive, give age.....no years
7. Birth date of deceased (mo., day, yr.).....1874

8. AGE: Years.....74 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Snowhill md
(Town, county, and state)

10. Usual occupation.....Farmer

11. Industry or business.....same as above

12. Name.....Lagbert Duffield

13. Birthplace.....Snowhill md

14. Maiden name.....Elizabeth Parker

15. Birthplace.....Parsonage md

16. Informant.....Mrs. Mardella Johnson

Address.....Salisbury md

17. Burial Date thereof.....2/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Friendship

Location.....near Snow Hill md

18. Funeral director.....James Stewart

Address.....Salisbury md

19. 3/3 1948 Registrar.....James Stewart
(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Jan 30 1948 at.....11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Sept 20 1947 to.....Jan 30 1948
and that I last saw him alive on.....Jan 30 1948

Immediate cause of death.....Carcinoma of Liver

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Phyllis Lusk

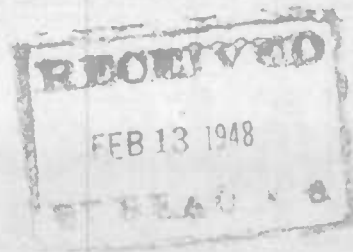
Address.....Salisbury md

Date signed.....2-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.



UNITED STATES DEPARTMENT OF JUSTICE

STATE OF TEXAS

IN THE DISTRICT COURT OF THE

COUNTY OF DALLAS

RECEIVED
JAN 28 1948
ST. PAUL, MINN.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico
 City or town Bivalve
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Wicomico
 City or town Bivalve
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joseph W. Dunn
 4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced widower

3. (b) Social Security Number

6.(b) Name of husband or wife Annie Dunn

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1869 6.(c) If alive, give age _____ years

8. AGE: Years 81 Months - Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Bivalve, Wicomico, Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name unknown13. Birthplace "14. Maiden name unknown15. Birthplace "16. Informant Viola BarefootAddress Washington, D. C.17. Burial Date thereof 1/29/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory M. E. Church CemeteryLocation Bivalve, Md.18. Funeral director C. E. MessickAddress Bivalve, Md.19. Jan. 29, 1948 R. Bulford Walker

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29, 1948 at 1:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Sept 1947 to 27 Jan 1948
 and that I last saw him alive on 27 Jan 1948

Immediate cause of death Uremic azotemia DURATION 2 days

Due to Prostatic Obstruction Survival time

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard H. Saunders III

M. D. or other

Address Northside Md Date signed 27 Jan 48

STANDARD OF COMMERCE

STANDARD OF COMMERCE

STANDARD OF COMMERCE

STANDARD OF COMMERCE

RECEIVED
JAN 31 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
415 Davis St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Virginia Dunn

3. (b) Social Security Number

4. Sex F. 5. Color of race W. 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Franklin S. Dunn7. Birth date of deceased (mo., day, yr.) Aug 9, 1883 6. (c) If alive, give age _____ years8. AGE: Years 64 Months 4 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Bivaloe Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Hiram P. Harsman13. Birthplace Bivaloe, Md.14. Maiden name Mary Harsman15. Birthplace Bivaloe Md.16. Informant Robert F. DunnAddress Salisbury Md.17. Burial Date thereof 1/9/48
(Burial, cremation, or removal-Which) (month) (day) (year)Cemetery or crematory Bivaloe, Md.Location Bivaloe, Md.18. Funeral director David F. MeserachAddress Salisbury Md.19. 1/8, 1948 Robert F. Dunn
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1948 at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6-11, 1946 to Jan 6, 1948 and that I last saw her alive on Jan 6, 1948Immediate cause of death Respiratory FailureDue to Cerebral hemorrhageDue to Hypertension + arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Robert F. Dunn

M. D. or other

Address Salisbury, Md. Date signed 1-8-48

RECEIVED

FEB 2 1948

STANDARD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00988 330

1. PLACE OF DEATH:

County Hicomicus
 City or town Mardela
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State md County Hic
 City or town Mardela
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Eugene Elliott

3. (b) Social Security Number

4. Sex M 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Hessie R. Elliott
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) March 1872

8. AGE: Years 75 Months 10 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Mardela RD. Hic Md
 (Town, county, and state)

10. Usual occupation Barber

11. Industry or business

12. Name William E. Elliott13. Birthplace md14. Maiden name Sarah Elliott15. Birthplace md16. Informant Mrs Hessie R. ElliottAddress Mardela, Md17. Burial Date thereof 1. 6 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MardelaLocation Mardela, Md.18. Funeral director Gregg BrosAddress Shaytown19. 1/6/48 19. 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4, 1948 at 7 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8th 1947 to Jan 4, 1948
 and that I last saw him alive on Jan. 28th 1948

Immediate cause of death Paralysis -

DURATION

Due to Cerebral hemorrhageDue to residual Cerebral hemorrhageOther conditions none

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

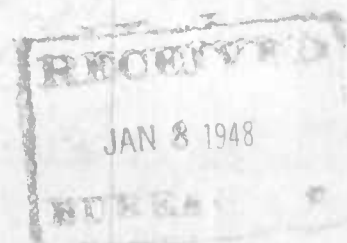
Means of injury _____ Injured at work? _____

23. SIGNATURE W. E. Elliott MD

M. D. or other

Address Mardela, MdDate signed Jan 5, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:

County..... Wicomico
 City or town..... Salisbury RFD 1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 35 years
 Hospital, institution, or street address where death occurred.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... New Jersey County..... Monmouth
 City or town..... Belmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1707 H St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Joe Evans

3. (b) Social Security Number

157-18-2617

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... single

6.(b) Name of husband or wife..... 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May 4, 1888

8. AGE: Years..... 59 to Months..... 8 Days..... 4 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md
 (Town, county, and state)

10. Usual occupation..... Painter

11. Industry or business.....

MOTHER FATHER
 12. Name..... Edmund Evans
 13. Birthplace..... England
 14. Maiden name..... Mary Ann Costello
 15. Birthplace..... England

16. Informant..... Ruth Evans

Address..... Salisbury, Md RFD

17. Burial Date thereof..... Jan 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Evergreen

Location..... Elizabeth City, N. J.
W. L. Marwick Co

18. Funeral director..... Delmar 22nd

Address.....

19. 1/10 19 48 Marie C. L. Johnson
 (by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 8 19 48, at 2:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him..... alive on.....
 Immediate cause of death.....
Fractured skull
Co. fracture left tibia
& fibula

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... 1/8/48

Where did injury occur?..... Salisbury Wicomico Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Highway

Means of injury..... Pedestrian struck Injured at work?..... No

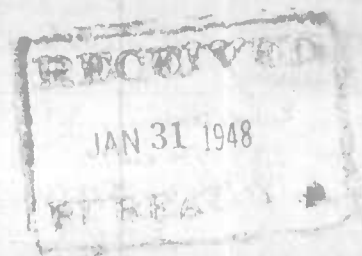
by..... bus & van

23. SIGNATURE..... LaRademahr MD

Address..... Deputy Med Examiner M. D. or other.....
Salisbury, Md Date signed..... 1/12/48

DURATION

Instant
death



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 999

1. PLACE OF DEATH:

County Washington
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred Pennsylvania General Hospital

How long in hospital or institution? 10 days

3. (a) FULL NAME

Mamie B Fairbank

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced S.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Mar 31 1873

8. AGE: Years 73 Months 9 Days 24 It less than one day

9. Birthplace Eastern, Talbot Co Md
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name John B. Fairbank

13. Birthplace Md

14. Maiden name Margaret E. Bridges

15. Birthplace Md

16. Informant Mrs E. H. Benson

Address Bethesda Md

17. Burial Date thereof 1/25/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Eastern Md.

18. Funeral director Anna D. Burroughs

Address Bethesda Md.

19. 1/24 1948 Mamie B. Fairbank Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Washington

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. Main
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1948 at 59 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 1/22 1948

Immediate cause of death Broncho-Pneumonia DURATION

Due to

Due to Fractured Right Leg

Other conditions at the neck

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/12/48

Where did injury occur? Bethesda (City or town) Md (County) (State)

Injured at home, farm, industry, public place (Where?) Home

Means of injury slipped & fell Injured at work?

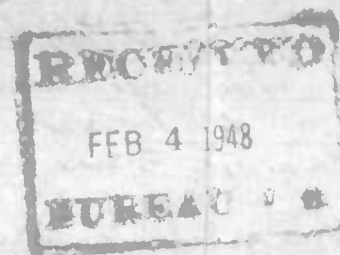
Signature J. E. Antonsen MD. M. D. or other

Address Pennsylvania City Md Date signed 1/24/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00991

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State MD. County DorchesterCity or town Rhodesdale
(If outside city or town limits, write RURAL and give nearest town)Street No. R.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Fooks, Mr Wilson

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Victoria Fooks6. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) Nov. 12 - 18658. AGE: Years 82 Months 2 Days 18 If less than one day
.....hrs.min.9. Birthplace Proctor Co. Md.
(Town, county, and state)10. Usual occupation Retired Farmer + Lumberman11. Industry or business William Fooks12. Name Proctor Co. Md.13. Birthplace Elizabeth Snyder14. Maiden name Proctor Co. Md.15. Birthplace My Mother L. Fooks16. Informant D. Rhodesdale Md.17. Burial Date thereof Feb. 1 - 1948
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory Fisher Family Cem.Location near it. Sal. (Proctor Co. Md.)18. Funeral director William R. MillerSalisbury Maryland19. 2/1/48 1948 Harriet L. Johnson
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1948 at 1⁰⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1947 to Jan 30 1948
and that I last saw him alive on Jan 30 1948Immediate cause of death Carcinoma of prostate DURATION 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations NoneAutopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injury at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Rademaker MD M. D. or otherAddress Salisbury, Md Date signed 1/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00992

Reg. Dist. No. 333

1. PLACE OF DEATH: *McCormick*
County *Salisbury*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *3 years*
Hospital, institution, or street address where death occurred:
415. Dams, st.
How long in hospital or institution: *(3 years at Wright's Nursing Home)*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *Md.* County *McCormick*
City or town *Maidela*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *Bridge street*
(If rural, give LOCATION)

3. (a) FULL NAME *Lottie Satter*

3. (b) Social Security Number

4. Sex *female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*
6. (b) Name of husband or wife *Charles S. Satter*
6. (c) If alive, give age *28* years
7. Birth date of deceased (mo., day, year) *Aug. 8th 1867*

8. AGE: Years *80* Months *08* Days *22* If less than one day _____ hrs. _____ min.

9. Birthplace *Maidela Md.*
(Town, county, and state)

10. Usual occupation *House wife*

11. Industry or business *Washington Sutter*

12. Name *Maidela Md.*

13. Birthplace *Unknown*

14. Maiden name

15. Birthplace

16. Informant *Mrs. Carrie L. Taylor*

Address *1263 Stevens Ave. Hallettsville Md.*

17. Burial (Burial, cremation, or removal, which?) *Buried* Date thereof *Feb 2-48*
(month) (day) (year)

Cemetery or crematory *Maidela Cem.*

Location *Maidela Maryland*

18. Funeral director *Hollaway & Co. R. Hollaway*

Address *Salisbury Md.*

19. *C. L. Taylor* 19 *48* Registrar *Harriet L. Taylor*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 30th 1948 5:30 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1-27-48* to *1-30-48* and that I last saw him alive on *1-30-48*

Immediate cause of death *Respiratory Failure* DURATION *1 hr*

Due to *Bilateral Pulmonary Tuberculosis*

Due to

Other conditions *Emaciation*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Robert J. Stone* M. D. or other

Address *Salisbury Md.* Date signed *2-2-48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, line/correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FFB 13 1948
EDM:GU 5 4

Dr. Rohler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00993

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2004 N. Division St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 2004 N. Division
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Thomas Nutter Hastings

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Alice M. Hastings6. (c) If alive, give age deceased years

7. Birth date of

deceased (mo., day, yr.)

Nov. 29 - 1865

8. AGE:

Years 82 Months 1 Days 29 hrs. min.

9. Birthplace

Wicomico, Delaware
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Clark Dry goods store

12. Name

Station Hastings

13. Birthplace

Wicomico, Del.

14. Maiden name

Elizabeth Callaway

15. Birthplace

Wicomico, Del.

16. Informant

Stanley F. Hastings

17. Address

#1. Front Lane Salisbury Md.

18. Burial

Jan. 30 - 1948

19. (Burial, cremation, or removal) Which?

Burial

20. Cemetery or crematory

Paris of the East

21. Location

Salisbury Md.

22. Funeral director

Hallam & Co. Walter R. Hallam

23. Address

Salisbury Md.

24. Date rec'd by registrar

1/30, 1948

25. Registrar

W. F. Callaway

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1948 1030p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19, 47 to Jan 28, 48and that I last saw him alive on Jan 27, 48

Immediate cause of death

Hemiplegia, right DURATION 2 weeksCerebral hemorrhage 2 weeksleftarteriosclerosis, generallized

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. F. Callaway, M.D.Address Salisbury Md. Date signed 1-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
10 1948
H. H. P. O. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corrected page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00994

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH

County McComie
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred: 722. Smith St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)
 State MD County McComie
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 422 Smith St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ellie S. Heath

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Elizabeth W. Heath
 7. Birth date of deceased (mo., day, year) Sept. 19-1890 6.(c) If alive, give age _____ years
 8. AGE: Years 57 Months 3 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Princeton Anne Md
 (Town, county, and state)
Auto. Mechanic

10. Usual occupation

11. Industry or business

12. Name Robert W. Heath13. Birthplace Princeton Anne Md14. Maiden name Mollie C. Musick15. Birthplace Chile Maryland16. Informant Mr. Edgar ButlerAddress 422. Smith St. Salisbury Md17. Burial Date thereof Jan 13-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory McComie Mem. ParkLocation Salisbury Md18. Funeral Director Hollingsworth & Walter R. HollingsworthAddress Salisbury Md19. 1/13/48 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1948 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9 1948 to Jan. 10 1948
 and that I last saw him alive on Jan. 10 1948

Immediate cause of death

Respiratory failureDue to Cerebral VascularAccidentDue to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE Robert R. StarrAddress SalisburyDate signed 1-12-48

RECEIVED

FEB 5 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Princess AnneCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Princess Anne General HospitalHow long in hospital or institution? 1 month & 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarcesterCity or town Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Holland, Lewiston

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.

Archie Holland

6. (c) If alive, give age _____ years

49

7. Birth date of deceased (mo., day, yr.)

May 10 - 1921

8. AGE:

Years 26Months 8Days 10

If less than one day _____ hrs. _____ min.

9. Birthplace

Princess Anne, Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

12. Name

John Hall

13. Birthplace

Maryland

14. Maiden name

Mary Shackles

15. Birthplace

Maryland

16. Informant

Archie Holland

Address

Snow Hill, Md Rural #1

17. Burial

Buried

Date thereof

Jan. 23/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Good Shepherd

Location

Good Shepherd, Md

18. Funeral director

Wm. E. Dymally

Address

Snow Hill, Md

19. Date rec'd by registrar

1/23/48

Registrar

Wm. E. Dymally

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1948, at 6:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12:15 1947, to 1:20 1948and that I last saw her alive on 1-19 1948Immediate cause of death chronic infection& general debilitation

DURATION

Due to

infected tropicalabscess left.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

infected uterine pregnancy

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

W. E. Dymally

M. D. or other

Address 204 N. Dymally St.Date signed 2/1/48

RECEIVED

FEB 5 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00995

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 5 days

3. (a) FULL NAME

Holliday Miss Evelyn May

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age ✓ years7. Birth date of deceased (mo., day, yr.) April 14, 1898

8. AGE:

Years

Months

Days

If less than one day

49875

hrs.

min.

9. Birthplace

Queen Hill, Thionis Co., Md.

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

George St. Holliday

13. Birthplace

Thionis Co., Md.

MOTHER

14. Maiden name

Margaret May Cadis

15. Birthplace

Thionis Co., Md.

16. Informant

Mrs. George St. Holliday

Address

Nebron, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

11/11/48
(month) (day) (year)

Cemetery or crematory

Nebron

Location

Nebron, Md.

18. Funeral director

The Hall & Johnson Co.

Address

Salisbury, Md.

19.

(Date read by registrar)

1/1/4919. 48Barrett E. Johnson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Thionis

City or town

Nebron

Street No.

Mar - St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan. 8 -19. 48 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 319. 48 to Jan 819. 48and that I last saw her alive on Jan 919. 48

Immediate cause of death

Generalized carcinoma

DURATION

6 monwith marked debilitation

Due to

pseudomeningeal carcinoma of left ovary2 yrs

Due to

Other conditions

marked debilitation1 monand dyspareunia

(Include pregnancy within 3 months of death)

Major findings of operations

carcinoma of left ovary with metastases

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

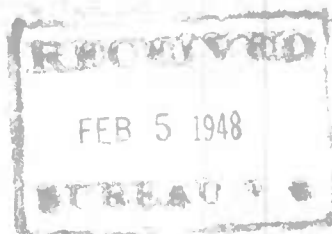
23. SIGNATURE

H. B. Prile

M. D. or other

Address

5047 Quinson St.Date signed 1. 9. 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00996

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Wicomico*
County *Salisbury*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, street address where death occurred:
120 Lincoln Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State *MD* County *Wicomico*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *120 Lincoln Ave*
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME *Willis C. Holloway*

3.(b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
6.(b) Name of husband or wife *Betha Ellen Holloway*
7. Birth date of deceased (mo., day, yr.) *Aug. 29 - 1908* 6.(c) If alive, give age *46* years
8. AGE: Years *39* Months *10* Days *10* If less than one day *hrs. min.*

9. Birthplace *P.O. Pocomoke Md.*
(Town, county, and state)
10. Usual occupation *Farmer*

11. Industry or business
12. Name *David James Holloway*
13. Birthplace *P.O. Pocomoke Md.*

MOTHER FATHER
14. Maiden name *Hermietta Baker*
15. Birthplace *Sumner Co. Del.*

16. Informant *Mr. Betha E. Holloway*
Address *120 Lincoln Ave. Salisbury Md.*

17. Burial, cremation, or removal, where? *Buried* Date thereof *Jan 11 - 48*
(month) (day) (year)
Cemetery or crematory *Wicomico Mem. Park*
Location *Salisbury Md.*

18. Funeral director *Holloway & Co. Walter R. Holloway*
Address *Salisbury Maryland*

19. *1/11/48* Date rec'd by registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH *Jan 9 - 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 1* 19 *47* to *January 9* 19 *48*
and that I last saw him alive on *Dec 6* 19 *48*

Immediate cause of death *Sprue*
Sprue

Due to
Due to

Other conditions *Emaciation*
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Injured at work?

23. SIGNATURE *W. Sobler M.D.*
M. D. or other
Address *Salisbury, Del.* Date signed *10 Jan 1948*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 31 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00997

Reg. Diat. No. 335

1. PLACE OF DEATH:

County Wilcomica
 City or town Sharptown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wilcomica
 City or town Sharptown Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION) no
 2.(a) If veteran, name war no

3.(a) FULL NAME

George W Hopkins

3.(b) Social Security Number

no

4. Sex male 5. Color or race a.g. 6.(a) Single, married, widowed, or divorced Married
 8.(b) Name of husband or wife Leah Hopkins
 7. Birth date of deceased (mo., day, year) Yes 8.(c) If alive, give age Don't know years
 8. AGE: Years 89 Months - Days - If less than one day about 185-9 hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1948 at 2:45 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to Jan 17 1948
 and that I last saw him alive on Jan 17 1948
 Immediate cause of death Cerebral Thrombosis DURATION 10 hrs.
 Due to arteriosclerosis ?
 Due to _____
 Other conditions Chronic Venular Disease
 (Include pregnancy within 3 months of death)

9. Birthplace Welshpool Md (Town, county, and state)
 10. Usual occupation Farmer. He worked
 11. Industry or business same as above
 12. Name Washington Hopkins
 13. Birthplace Welshpool Md
 14. Maiden name Emeline Brown
 15. Birthplace Sharptown Md
 16. Informant Brother Brown
 Address Sharptown Md
 17. Burial Date thereof Jan 21 - 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Dion
 Location Sharptown
 18. Funeral director James H. Stewart
 Address Salisbury Md
 19. 1/20 1948 W. G. Mann
 (Date rec'd by registrar) Registrar

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. Kuhlman M. D. no
 Address Sharptown Md Date signed 1/20/48

RECEIVED
JAN 21 1948
BUREAU

VS A15

Address..... *N. Antelope Wd* Date signed *24* *June* *48*

RECEIVED

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JAN 28 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County DelawareCity or town Delishury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 2 hrs. 5 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County SussexCity or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph, Master Lemmy Lee4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

Dec 1 - 1947 6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

0127✓ hrs.

min.

9. Birthplace

Delaware
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, Which?)

Date thereof Jan 30 - 48
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

1/29 19 48

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 19 48 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 19 48 to Jan 28 19 48
and that I last saw him alive on Jan 28 19 48

Immediate cause of death

Acute gastro-enteritis

DURATION

2 days

Due to _____

Due to _____

Other conditions

Dehydration, severe

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

D.V. Foller, M.D.
Address Delmar Del Date signed 1-28-48

12/1-47 - del.

Geo. A. Joseph del. -

Margaret Leachman P.P.

- Tamm del.

1/20-48 Filing - 2 P.M. →

- Religion & Human Rights

- R. Clough - ✓



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01003

1600

Reg. Dist. No. 399

1. PLACE OF DEATH:

County HarrisCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial General Hospital

How long in hospital or institution?

9 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County LancasterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lager, Baby Girl

3. (b) Social Security Number

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Jan. 6, 1948 (2.13 a.m.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

9 hrs. 7 min.

9. Birthplace

Salisbury, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

CLIN C. LAGER

13. Birthplace

PENNA

MOTHER

14. Maiden name

EVELYN DAVIS

15. Birthplace

PENNA

16. Informant

Address

REV. O. G. LAGERBERLIN, MD

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

ST. PAUL'S CHURCH YARD

Location

BERLIN, MD

18. Funeral director

Address

Anna A. BurbonBerlin, Md.

19.

(Date rec'd by registrar)

19.

48PassportJohn E. Johnson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1948 at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 19....., 19.....

and that I last saw him/her alive on

19.....

Immediate cause of death

atelectasis

DURATION

Due to

Prematurity

Due to

Placenta Praevia

Other conditions

none

(Include pregnancy within 8 months of death)

Major findings of operations

no operation

Autopsy results

atelectasis + prematurity

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John E. Johnson

M. D. or other

Address

124 E. Main St.Date signed 1/6/48

RECEIVED

JAN 31 1948

OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5 Claremont Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elestine Eliza Lareman

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife James F. Lareman
 7. Birth date of deceased (mo., day, yr.) Sept 3, 1858
 6.(c) If alive, give age _____ years

8. AGE: Years 89 Months 4 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Groesbeek, Somerset, Md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business Home

12. Name Noah James
 13. Birthplace Groesbeek, Md.

14. Maiden name Ernest Nelson
 15. Birthplace Groesbeek, Md.

16. Informant Harold Lareman, Sr.
 Address Salisbury, Md.

17. Burial Date thereof Jan 10, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Groesbeek Cemetery
 Location Groesbeek, Md.

18. Funeral director H. H. Harny Bros.
 Address Groesbeek, Md.

19. 1/10/48 Registrar W. H. Harny
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8, 1948 at 11:12 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26, 1947 to Jan 8, 1948
 and that I last saw her alive on Jan 7, 1948

Immediate cause of death Respiratory failure
Arteriosclerosis
and Senility

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert R. Starr M. D. or other _____
 Address Salisbury Date signed 1-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 31 1948

FINANCIAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01001

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Second St
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME

Lee, Mary Lena

3.(b) Social Security Number

no

4. Sex Female 5. Color or race a.a. 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife Archie Lee

7. Birth date of deceased (mo., day, yr.) 2-10-1885 6.(c) If alive, give age - years

8. AGE: Years 62 Months 11 Days 10 If less than one day hrs. min.

9. Birthplace James Quarter, Somerset Co., Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Same as above

12. Name Henry Wigfall

13. Birthplace North Carolina

14. Maiden name Emily Stewart

15. Birthplace Revels Neck, Somerset Co., Maryland

16. Informant Mildred Tasker

Address Salisbury, Md.

17. Burial Date thereof 1-25-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory James Quarter

Location James Quarter, Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury, Md.

19. 1/23 19 48 Wassie C. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1948 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 1948 to January 20, 1948

and that I last saw her alive on January 19, 1948

Immediate cause of death Apoplexy

Due to Hypertension

Due to Indefinite

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Parnell, M.D.

Address 800 W. Main St. Salisbury, Md.

Date signed 1/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 4 1948

BUREAU V 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01002

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *McCombs*
County: *Willards*
City or town: *Willards*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new deaths give residence of mother)
State: *Md.* County: *McCombs*
City or town: *Willards*
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME *Annie E. Lewis*

3. (b) Social Security Number

4. Sex: *Female* 5. Color or race: *White* 6. (p) Single, married, widowed, or divorced: *Married*
6. (b) Name of husband or wife: *Earnest C. Lewis*

7. Birth date of deceased (mo., day, yr.): *June 16-1887* 6. (c) If alive, give age: *60* years

8. AGE: Years: *60* Months: *7* Days: *15* If less than one day: *hrs. min.*

9. Birthplace: *Willards Md.*
(Town, county, and state)

10. Usual occupation: *House wife*

11. Industry or business

12. Name: *Lamont Edward Smith*

13. Birthplace: *P.O. Willards Md.*

14. Maiden name: *Alice M. Prosser*

15. Birthplace: *Berlin Md.*

16. Informant: *M. Earnest C. Lewis*

Address: *Willards Maryland*

17. Burial: *Buried* Date thereof: *July 3-48*
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery: *Willards Cem.*
Location: *Willards Maryland*

18. Funeral director: *Walter R. Hollman*
Address: *Salisbury Md.*

MEDICAL CERTIFICATION
20. DATE OF DEATH: *Jan. 31st* 19*48* at *7:15 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 1* 19*47* to *day of death* 19*48*
and that I last saw him alive on *day of death* 19*48*

Immediate cause of death: *Adenocarcinoma of descending colon*

Due to: *Adenocarcinoma of descending colon*

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

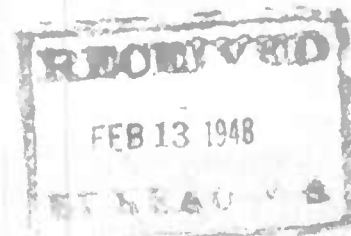
23. SIGNATURE: *Frank E. Lewis M.D.* M. D. or other

Address: *Willards Md.* Date signed: *Feb 1, 1948*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01004

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Willards
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

En route to Hospital, P. K. 16

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County WicomicoCity or town Willards
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lewis, Mr. John

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

✓

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb. 9, 1884

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

631117

hrs.

min.

9. Birthplace

Willards, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Geniah Lewis

13. Birthplace

Del.

MOTHER

14. Maiden name

Hennie Parsons

15. Birthplace

Del.

16. Informant

Willie Lewis

Address

Willards, Del.

17.

(Burial, cremation, or removal, Which?)

Date thereof

1/28/48
(month) (day) (year)

Cemetery or crematory

New Hope Cem.

Location

Willards, Del.

18. Funeral director

Address

Wm. L. Latham, Inc.
Salisbury, Del.

19.

(Date'd by registrar)

19.

48Harriet L. Latham
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 19 48, at 12:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw medically alive on 2/2/48 19 48

Immediate cause of death

Crushed Chest
Fractured left femur

DURATION

1 hr
1 hr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidentDate of 1/26/48

Where did injury occur?

Willards
(City or town)Wicomico
(County)Del.
(State)

Injured at home, farm, industry, public place (where?)

Forest

Means of injury

ground covered

Injured at work?

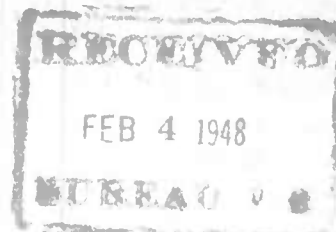
Yes

23. SIGNATURE

Harriet L. Latham
Physician with license or other

Address

Salisbury, Del.Date signed 1/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The **secret** age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Noon.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

01005

CERTIFICATE OF DEATH

Reg. Diat. No. **333**

I. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula Surgical HospitalHow long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mills Elton

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

e

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mills Nettie

7. Birth date of deceased (mo., day, yr.)

Sept. 25 - 1892

6. (c) If alive, give age

52 years

8. AGE:

Years 55 Months 3 Days 20 hrs. _____ min. _____

9. Birthplace

Frederick, Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

George Mills

12. Name

13. Birthplace

Maryland

14. Maiden name

Elizabeth L. Rowley

15. Birthplace

Maryland

16. Informant

Nettie H. Mills

Address

Snow Hill, Md Rural #2

17. Burial

Burial

Date thereof

Jan 29/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Luke's Chapel

Location

Snow Hill, Md

18. Funeral director

Elmer O. Williams

Address

Snow Hill, Md

19. Date received by registrar

1/30/48

Registrar

W. H. Webb

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 18 - 1948 at 10:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 30 to Jan 15 1948and that I last saw him alive on Jan 15 1948

Immediate cause of death

Myocardial InfarctionHeartArteriosclerosisHypertensionDiabetesObesityCholesterolOther conditionsNoneNoneNoneNoneNoneNoneNoneNoneNoneNone

DURATION

Major findings of operations

None Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

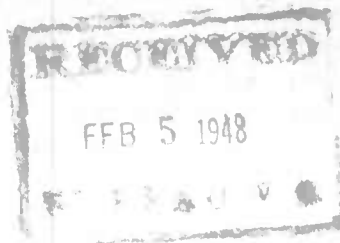
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

W. H. Webb M. D. or other _____Address Salisbury, Md Date signed 1/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01006

108

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
P. G. Hospital
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no ✓

3. (a) FULL NAME

Murdock, Annie

3. (b) Social Security Number

218-20-3259

4. Sex

Female

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Eugene Murdock

7. Birth date of deceased (mo., day, yr.)

Oct. 10 - 1890

6. (c) If alive, give age 39 years

8. AGE:

Years 57 Months 3 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace

Seaboard, North Carolina
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Cryogenic

MOTHER FATHER

12. Name

Richard Harris

13. Birthplace

North Carolina

14. Maiden name

Mar. Luc. Harris

15. Birthplace

North Carolina

16. Informant

Eugene Murdock

Address

Snow Hill, Md.

17. Burial, cremation, or removal

Burial Date thereof Jan. 14/48
 (month) (day) (year)

Cemetery or crematory

Baptist

Location

Snow Hill, Md.

18. Funeral director

Elmer E. Dennis

Address

Snow Hill, Md.

19. Date rec'd by registrar

1/14/48 19 48 Registrar Salisbury, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 19 48 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 19 47 to Jan 11 19 48

and that I last saw her alive on Jan 11 19 48

Immediate cause of death

Pneumonia lobaa

DURATION

16 days

Due to

Due to

Other conditions

Cerebro-vascular system

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

James R. Mearns M. D. or other _____

Address Salisbury, Md. Date signed 1/11/48

RECEIVED

FEB 5 1948

BUREAU

Dr. Hames

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:
625 N. Main street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 625 N. Main st
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Harvey James Parker

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Emma F. Parker

7. Birth date of

deceased (mo., day, yr.)

June 9 - 1868

6. (c) If alive, give age

77 years

8. AGE:

Years

Months

Days

If less than one day

79717

hrs.

min.

9. Birthplace

Pittsville Maryland
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or other)

Date there

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1/27/48RegistrarJohn

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 24th

19

at

8:30p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan

19

to

Jan 24th

19

48

and that I last saw him alive on

Jan 24th

19

48

Immediate cause of death

DURATION

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

32. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Rademaker MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01008

Reg. Dist. No. 333

1. PLACE OF DEATH: McComie
County Salisbury
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
413-Dans St. (Aught Home)
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For children infants give residence of mother)
State Md. County McComie
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RIO #3
(If rural, give LOCATION)

3. (a) FULL NAME Lillie M. Peck

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife William O. Peck

7. Birth date of deceased (mo., day, yr.) June 3rd 1857 6. (c) If alive, give age Dead years

8. AGE: Years 90 Months 7 Days 22 If less than one day
hrs. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Charles Sligh

13. Birthplace mt Vernon N.Y.

14. Maiden name Delia Odell

15. Birthplace New York N.Y.

16. Informant Mrs. Marjorie Ratto

Address RIO #3 Salisbury Md

17. Buried Date thereof Jan. 8-28-48

(Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Church

Location Salisbury Md.

18. Funeral director Hallman G. V. Walter R. Hallman

Address Salisbury Md.

19. 1/18/48 19 48 Barriett & Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25th 48 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive examined autopsy 19

Immediate cause of death Coronary Thrombosis

DURATION

6 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Car Injured at work?

Signature Dr. Rademaker MD

23. SIGNATURE Dr. Rademaker MD

Address Salisbury Md Date signed 1/26/48

MARGIN RESERVED FOR BINDING

I

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Maryland
 City or town Pittsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Neomine
 City or town Pittsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. P.O. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Edna Mae Pudner

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas J. Pudner

7. Birth date of deceased (mo., day, yr.)

May 29-1885

6. (c) If alive, give age

60 years

8. AGE:

Years

62

Months

7

Days

10

If less than one day

hrs. min.

9. Birthplace

Neomine G. Md.

(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

Edward Warren

12. Name

Neomine G. Md.

13. Birthplace

John C. Pannoni

14. Maiden name

R.P. Pittsville Md.

15. Birthplace

M. Thomas J. Pudner

16. Informant

P.O. #1, Pittsville Md.

Address

Buried

17. (Burial, cremation, or removal. Which?)

Warren Em.

Cemetery or crematory

P.O. #1, Pittsville Md.

Location

William G. Walter R. Williams

18. Funeral director

Salinity Md.

Address

19. 1/13, 1948

(Date rec'd by registrar)

19. 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9th 1948 at 9:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 40 to day of deathand that last saw her alive on day of death

Immediate cause of death

myocarditis chronic

DURATION

2 yrs.

Due to

Chronic infections attributed

Other conditions

with extensive deformity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature

Frank R. Lewis Sr. D.

M. D. or other

Address Pittsville Md.Date signed 1-12-48

RECEIVED

JAN 31 1948

ET 554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

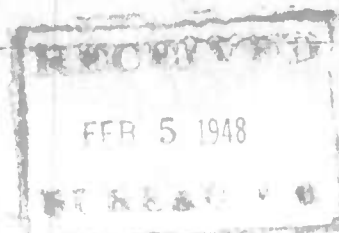
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01010

Reg. Dist. No. 333

1. PLACE OF DEATH: County <u>Wicomico</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 days</u> Hospital, institution, or street address where death occurred: <u>410. Record Street</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Wicomico</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>410. Record St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war	
3. (a) FULL NAME <u>Robert J. Prettyman</u>		3. (b) Social Security Number	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (g) Single, married, widowed, or divorced <u>Widower</u>	
6. (b) Name of husband or wife <u>Orin E. Prettyman</u>		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Jan. 14th</u> 19 <u>48</u> at <u>5:55p</u> M	
7. Birth date of deceased (mo., day, yr.) <u>March 22-1886</u>		I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 13,</u> 19 <u>48</u> , to <u>Jan 14,</u> 19 <u>48</u> , and that I last saw him alive on <u>Jan 14,</u> 19 <u>48</u> .	
8. AGE: Years <u>61</u> Months <u>9</u> Days <u>22</u> hrs. min.		Immediate cause of death. <u>Cerebral Hemorrhage</u>	
9. Birthplace. <u>Laurel Del.</u> (Town, county, and state)		Due to. <u>Arteriosclerosis</u>	
10. Usual occupation. <u>Laborer</u>		Due to.	
11. Industry or business. <u>Cornelius Prettyman</u>		Other conditions.	
12. Name. <u>Sussex Co Del.</u>		(Include pregnancy within 3 months of death)	
13. Birthplace.		Major findings of operations.	
14. Maiden name. <u>Unknown</u>		Date of op.	
15. Birthplace.		Autopsy results.	
16. Informant. <u>Mrs. Elsie Prettyman</u>		PHYSICIAN. Please underline the cause to which death should be charged statistically.	
Address. <u>410. Record St, Salisbury Md</u>		22. VIOLENCE: If death was due to external causes, fill in the following:	
17. Burial. <u>Parson Cem.</u> Date thereof <u>Jan. 17-48</u>		Accident, suicide, or homicide. Date of	
Cemetery or crematory.		Where did injury occur? (City or town) (County) (State)	
Location. <u>Salisbury Md</u>		Injured at home, farm, industry, public place (where?)	
18. Funeral director. <u>William R. Hillyer</u>		Means of injury Injured at work?	
Address. <u>Salisbury Md</u>		23. SIGNATURE. <u>John H. Yeaman M.D.</u>	
19. Date rec'd by registrar. <u>1/17/48</u>		Address <u>Salisbury Md</u> Date signed <u>1-14-48</u>	



Indicate for
Change of State
Show on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01011

FILE NO. G 114 FEB 25 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year - 9 months
Hospital, institution, or street address where death occurred:
1806 N. Division St.
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1806 N. Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Charles W. Reike

3. (b) Social Security Number

✓

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Anna Evelyn Reike
7. Birth date of deceased (mo., day, yr.) September 1, 1867 6.(c) If alive, give age 77 years
8. AGE: Years 80 Months 5 Days 28 If less than one day
hrs. min.

9. Birthplace Maucha Chunk Pa.
(Town, county, and state)
10. Usual occupation Bank Auditor

11. Industry or business
12. Name John Reike
13. Birthplace Germany
14. Maiden name Charlotte Muller
15. Birthplace Ducks Co. Pa.

16. Informant Mrs. Ralph C. Bulant
Address 3 Rutland Maryland
17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 2/13/48
(month) (day) (year)
Cemetery or crematory Long Hill Cemetery
Location Mt. Airy, Phila. Pa.

18. Funeral director The Phil & Johnson Co.
Address Salisbury, Maryland
19. 1/30, 1948 Registrar Charles E. Johnson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1948 at 5:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 3, 1948 to Jan 29, 1948
and that I last saw him alive on Jan 28, 1948
Immediate cause of death

Cardio-vascular renal disease

Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Phyllis A. Jones M. D. or other
Address Salisbury Md Date signed 1-30-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico
City or town Isaiah
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Wicomico
City or town Isaiah
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Laura R. Serye

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Dennis Serye

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1868

8. AGE: Years 79 Months 10 Days 5 If less than one day hrs. min.

9. Birthplace Quantico, Wicomico, md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Samuel Jones

13. Birthplace Quantico, md.

14. Maiden name Maria H. Jones

15. Birthplace Quantico, md.

16. Informant Maria Sattis

Address Isaiah, md.

17. Burial Date thereof 1/18/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Old Town Cemetery

Location White Haven, md

18. Funeral director B. G. Messers

Address Bevalve, md.

19. Jan 16 19 48 R. H. Holford
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 19 48 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 November 19 47, to 15 January 19 48
and that I last saw h. alive on 15 January 19 48

Immediate cause of death Arterio-sclerotic Cardiac -
Vascular Renal Disease

Due to Arterio-sclerosis

Due to

Other conditions Gastric Cancerous
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard H. Saunders MD
M. D. or other
Address Route 100 Date signed Jan 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 21 1948
FBI - NEW YORK

Evidence for the change of
date of birth is shown
on G 114 2/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01013

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wilcomita
City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Wilcomita
City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 500 Muldon St
(If rural, give LOCATION) no
2.(d) If veteran, name war no

3. (a) FULL NAME

Maud Selby

3. (b) Social Security Number

4. Sex female 5. Color or race a.a. 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Grant Selby

7. Birth date of deceased (mo., day, yr.) may 11 - 1891 1890

8. AGE: Years 57 Months - Days - It less than one day hrs. min.

9. Birthplace Salisbury md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name John M Leonard

13. Birthplace Salisbury md

14. Maiden name Annie Leonard

15. Birthplace Salisbury md

16. Informant Mrs Alice Taylor

Address Salisbury md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan 15 - 1948
(month) (day) (year)

Cemetery or crematory Green acres

Location Salisbury md

18. Funeral director James H. Stewart

Address Salisbury md

19. 1/15 - 1948 Registrar Arthur D. Browne

(Date rec'd by registrar) 19 48

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 19 48 at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5, 1947 to Jan 13 19 48

and that I last saw her alive on Jan 13 19 48

Immediate cause of death Organic Heart Disease

Due to ?

Due to ?

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations ?

Autopsy results ?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ? Date of ?

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Arthur D. Browne M.D.

Address Salisbury md Date signed 1/15/48

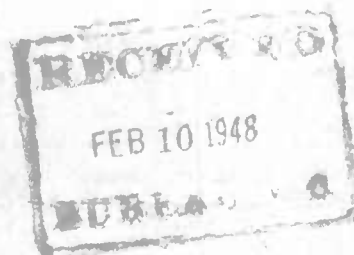
MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1948
BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico County
City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 days

3. (a) FULL NAME

Eliza C Showell

4. Sex

Female, Col.

5. Color or race

Married.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Charles Showell

7. Birth date of

deceased (mo., day, yr.) 1888

6. (c) If alive, give age years

8. AGE:

Years 60Months -Days -

If less than one day

..... hrs. min.

9. Birthplace

Wicomico County
(Town, county, and state)

10. Usual occupation

Domestic.

11. Industry or business

None

12. Name

Sandy Parsons

13. Birthplace

Wicomico Co.

14. Maiden name

Annie Parsons

15. Birthplace

Wicomico Co.

16. Informant

Charles Showell

Address

Parsonsburg, Md.

17. Burial

Class Hill Cem

Cemetery or crematory

Parsonsburg, Md.

18. Funeral director

Boaker Dr. Quest

Address

Salisbury, Md.

19. (Date read by registrar)

1/17/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town New Pittsville
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1948 at 3:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Cancer of stomach

DURATION

1 year

Due to

Due to

Other conditions

Some secondary anemia
hypostatic pneumonia
(Include pregnancy within 3 months of death)3 weeks10 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

L. J. Gohler, M.D.
M. D. or other
Address Salisbury, Md. Date signed 1-15-48

RECEIVED

FEB 5 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01016

1960

Reg. Dist. No. 333

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Delaware County... Sussex
 City or town... Delmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 302 Lincoln
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

William Lewis Smith

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1907

8. AGE: Years 40 Months 1 Days 24 If less than one day
hrs.min.

9. Birthplace... Wilmington, Del.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Oscar Smith
 13. Birthplace Farmington, Del.
 14. Maiden name Ida C. Kates
 15. Birthplace Felton, Del.

16. Informant Mrs. Ida C. Smith

Address Delmar, Del

17. Burial Date thereof Jan. 26, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ Hollywood

Location Harrington, Del.

18. Funeral director W.S. Marvel Co.

Address Delmar, Del.

19. 1/25 1948 Harriet E. Johnson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1948 at 10⁴⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 and that I last saw him medically alive on Jan. 24, 1948
 Immediate cause of death Fractured skull
Brain laceration

Other conditions Pneumonia
terminal
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op.

Due to
 Due to

Other conditions as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 1/23/48
 Where did injury occur? Delmar (City or town) Sussex (County) Del. (State)
 Injured at home, farm, industry, public place (where?) home
 Means of injury slipped down injured at work? no
cellar stairs

23. SIGNATURE Harriet E. Johnson M.D. or other
 Address Salisbury, Md. Date signed 1/25/48

RECEIVED
FEB 4 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1116 N. Main Street

How long in hospital or institution?

3. (a) FULL NAME

Hillary M. Taylor

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1116 N. Main St.

(If rural, give LOCATION)

2. (a) If veteran, name war World War #1.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hattie Marion Byrd Taylor

7. Birth date of deceased (mo., day, yr.)

May 15 1896

6. (c) If alive, give age

52 years

8. AGE:

Years

Months

Days

If less than one day

51

8

8

hrs.

min.

9. Birthplace

Quantico, Md. (Wicomico Co.)
(Town, county and state)

10. Usual occupation

Distillation of Gas & Oil

11. Industry or business

Benj. H. Taylor Oil Co. Salisbury Md.

MOTHER

FATHER

12. Name

Benj. H. Taylor

13. Birthplace

Wicomico Co. Md.

14. Maiden name

Georgiana Hunsley

15. Birthplace

Mandela Md.

16. Informant

Mrs. Hattie M. Taylor

Address

1116 N. Main St. Salisbury Md.

17. Burial

Wicomico Co. Md. Jan. 1948

(Burial, cremation, or removal. Which?)

Mem. Park

Cemetery or crematory

Salisbury Maryland

Location

Salisbury Maryland

18. Funeral Director

Wolway Co. Walter R. Wolway

Address

Salisbury Maryland

19. Date rec'd by registrar

1/24/48

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 23^d 1948

CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Certificate

and that I last saw h. alive on 19

Immediate cause of death

Cerebral Hemorrhage

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver Fisher

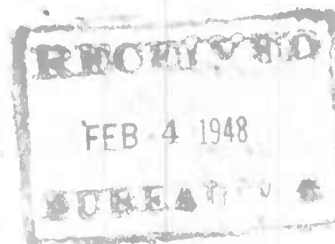
Address Salisbury Md. Date signed 1/23/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH *McComie*
 County *Dehon Ind.*
 City or town *Dehon*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
R.O. #2
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *MD.* County *McComie*
 City or town *Dehon*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *R.O. #2*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *Ollie Francis Jommend* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
 6. (b) Name of husband or wife *Ada Jommend*
 7. Birth date of deceased (mo., day, yr.) *July 8-1872*
 8. AGE: Years *75* Months *6* Days *4* If less than one day
 9. Birthplace *R.O. Presnoke Ind.*
 (Town, county, and state)

10. Usual occupation *Farmer*
 11. Industry or business *Farmer*
 12. Name *Alfred Jommend*
 13. Birthplace *R.O. Presnoke Ind.*

MOTHER
 14. Maiden name *Mary Carter*
 15. Birthplace *R.O. Presnoke Ind.*
 16. Informant *M. Frank Jommend*
 Address *113 Beckford Ave, Prince Georges Ind.*

17. *Buried* Date thereof *Jan. 15-48*
 (Burial, cremation, or removal, Which) (month) (day) (year)
 Cemetery or crematorium *Union Church*
 Location *near Presnoke Ind.*
 18. Funeral director *Stallings & Co. Waller R. Waller*
 Address *Salisbury Ind.*

19. *1/16-48* 19. *48* Registrar *W. Garrison*
 (Date rec'd by registrar)

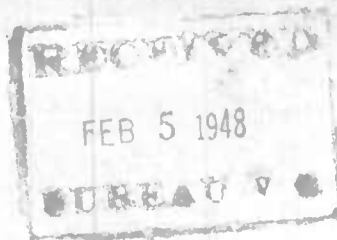
MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 12 48* at *10:45 PM*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *unattended*
 and that I last saw him alive on *19*
 Immediate cause of death *Coronary artery*
Stenosis

Due to *Unknown*
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please under the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Injured at work?
 23. SIGNATURE *Robert R. Stan*
 Address *Salisbury Ind.* Date signed *1-15-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01019

Reg. Dist. No. 339

1. PLACE OF DEATH:

County... *Thiompia*City or town... *Frederick (Rural)*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *four*Hospital, institution, or street address where death occurred:
*Re. Person, 1 hour*How long in hospital or institution? *1 hour*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Delaware* County... *Kent*City or town... *Abner*
(If outside city or town limits, write RURAL and give nearest town)Street No. *601 N. Bradford*
(If rural, give LOCATION)2.(a) If veteran, name war... *✓*

3. (a) FULL NAME

Harry H. Mumbauer, Jr.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

*Elaine Mumbauer*6. (c) If alive, give age *55* years

7. Birth date of

deceased (mo., day, yr.)

Oct. 18, 1889

8. AGE:

Years

Months

Days

It less than one day

*58**5**3*

hrs.

min.

9. Birthplace

Camden, New Jersey
(Town, county, and state)

10. Usual occupation

Shoemaker

11. Industry or business

Shoemaker

MOTHER

12. Name

Harry H. Mumbauer, Sr.

13. Birthplace

Not known

14. Maiden name

Anna Kuehn

15. Birthplace

Not known

16. Informant

Kenneth Mumbauer

Address

Abner, Del.

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

1/24/48
(month) (day) (year)

Cemetery or crematory

Location

Quaker Burial Ground

18. Funeral director

Re. N. Johnson Co.

Address

Salisbury, Md.

19. Date rec'd by registrar

*1/23/48*19 *48**Harry H. Mumbauer, Jr.*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *Jan. 21, 1948* at *11 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Medical Examiner Certificate*and that I last saw him on *Jan 21/48* 19 *48*

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

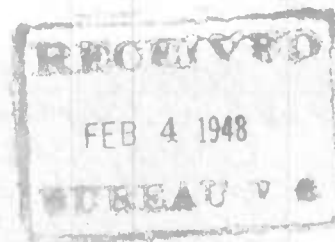
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

*Oliver T. Fushner*Address... *Salisbury, Md.* Date signed *1/24/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 339

01020

1. PLACE OF DEATH:

County Wicomico
 City or town (Burial) Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? from 9/27/47
 Hospital, institution, or street address where death occurred:
Eastern Shore Hosp. for
 How long in hospital or institution? 3 mo + 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County St Mary's
 City or town Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Leonardtown, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

George Richard Vallandigham

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 3/16/1898 5. (c) If alive, give age 49 years

8. AGE: Years 77 Months 9 Days 15 If less than one day hrs. min.

9. Birthplace St Mary's County
 (Town, county, and state)

10. Usual occupation Labourer

11. Industry or business

Farm

12. Name Samuel Vallandigham

13. Birthplace unknown

14. Maiden name Lida Lemon

15. Birthplace unknown

16. Informant from patient History taken

Address in admission to St. Mary's

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Jan. 7-1948
 (month) (day) (year)
 Cemetery or crematory Parson's Cem.
 Location Salisbury Md.

18. Funeral director Hillman & Co. Walter R. Hill
 Address Salisbury Md.

19. 1/1/48 (Date rec'd by registrar) W. H. Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/48 at 12⁰⁵ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/23 1947 to 1/1 1948
 and that I last saw him alive on 1/1/48 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 6 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Hill M.D. M. D. or other

Address Salisbury Md. Date signed 1/1/48

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FEB 2 1948

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